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CORRECTIONVILLE SPECIALTY CARE	**1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016**

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F 000	INITIAL COMMENTS Correction date: _____ The Correctionville Specialty Care Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written during the investigation of complaints #116629-A and #116630-A, conducted November 6, 2023 to November 20, 2023. Findings for complaints #116629-A and 116630-A will be sent to the facility at a later date under separate cover.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, law enforcement incident review, facility policy review, resident and staff interviews, the facility failed to keep residents safe from sexual abuse and financial	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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exploitation for 1 of 3 residents (Resident #1). Resident #1 reported a male Certified Nurse Aide (CNA) forced her to perform sexual acts on him. In addition, that male CNA and another CNA transferred money from her account using an electronic money transferring service. Despite the allegation of sexual abuse from the male CNA to Resident #1, the facility failed to prevent him from working with other vulnerable residents in the corporation.

Findings include:

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of 10/23/23 on 11/9/23 at 4:00 PM. The facility removed the IJ and decreased the scope to a "D" on 11/13/23 with the following actions:
a. The facility provided the following education:
i. Dependent adult abuse and sexual abuse including consensual vs. non-consensual education and the need to immediately report the allegation on 11/10/23.
ii. Spotting Signs of Elder Abuse to include caretaker boundaries on 11/10/23.
iii. The facility's expectations regarding purchasing personal items for residents on 11/10/23.
iv. Discharge/transfer policy, highlighted resident-initiated discharge including meeting the needs of Resident #1 welfare on 11/10/23.
v. Supervision of outdoor visits on 11/13/23.
b. The facility interviewed residents on all the alert and oriented residents on 11/11/23. In addition, the facility audited the remaining residents for any non-verbal signs of abuse.
c. The facility updated the Agency Orientation Checklist to include Abuse Protocol to highlight dependent adult abuse reporting policy and

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professional boundaries.

Resident #1's Minimum Data Set (MDS) assessment dated 9/24/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment reflected that Resident #1 did not have behaviors. Resident #1 required limited assistance from one person for transfers, dressing, toilet use, and personal hygiene. The MDS listed Resident #1 as frequently incontinent of urine and always continent of bowel. The MDS included diagnoses of disorder of the kidney, heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and malignant neoplasm of upper lobe (lung cancer). The assessment indicated that Resident #1 almost always had pain.

The Care Plan included the following Focuses dated 10/3/23:
a. Resident #1 planned to rehab to home. The Goal listed that Resident #1 would transition back to the community.
b. Activities of daily living (ADLs). The Interventions directed that Resident #1 could independently provide her own hygiene, toilet use, and transfers.
c. Resident #1 is independent in the facility. The Interventions reflected that Resident #1 used a front wheel walker.

The Discharge Summary note dated 10/25/23 at 12:00 PM, reflected that the facility discharged Resident #1 to a homeless shelter on 10/25/23.

The Sheriff's Office Incident Report dated 11/1/23 at 6:22 PM, reflected that a Sheriff's Office

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Representative interviewed Resident #1 about allegations of sexual abuse. She said that during her time as a resident in the nursing home, Staff I, CNA, sexually abused her. She stated that while taking care of her, Staff I would touch and kiss her inappropriately on the back of the neck and on her feet. She said that 2-3 weeks prior to her discharge, she went outside the facility to have a cigarette and it had been raining. Staff I asked if she would like to have her cigarette in his car and she agreed. He wheeled her to the car and while in the vehicle, he forced her to perform oral sex on him. She described the vehicle as a small red car parked by the row of trees near the highway.

On 11/14/23 at 2:15 PM, the Police Officer who interviewed Resident #1 on 11/1/23 described her as forthcoming but very embarrassed when she came in to the report abuse. He said that when she tried to describe what happened, she stumbled and had difficulty describing the sexual act. She mentioned being heavily medicated while at the facility and could not give consent. She told the officer that Staff I sent her a sexually explicit video of himself.

On 11/6/23 at 2:13 PM, Resident #1 said that when she reported her abuse to a couple of staff members, somehow, they twisted the story around. Due to this she did not trust anyone at the facility any more. She said that the Administrator came into her room one day, yelling, and told her that she had to leave because the staff reported that she provided sexual favors for cigarettes. Resident #1 said that staff took her outside to have cigarettes, and she shared with a couple of them. Staff I sexually attacked her. She could not remember the date

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when Staff I took her to his car and made her perform oral sex on him. She said that he treated her nice and spent time with her. She thought that she may have gave him the wrong impression when she sent him texts. He then sent her a video of him pleasuring himself.

When asked to share the sexually explicit video for the investigation, on 11/9/23 Resident #1 sent the video of a male masturbating. The phone revealed that Staff I sent it from his phone. In addition to the text transactions, Resident #1's phone included the transfer of money from her account to Staff I's Cash App on 10/16/23.

On 11/15/23 at 2:20 PM, Resident #1 said that she took a lot of pain medications at the facility, that made her mind fuzzy, and she could not be clear on the actual date of the incident. She remembered that Staff I sent the sexually explicit video after the incident, but before the Cash App transfer because he told her about the video when he had her in the car (A screenshot of text messages between Staff I and Resident #1 confirmed that Staff I sent the explicit video on 10/12/23). Resident #1 said that initially, she felt very safe with Staff I. He spent time with her, took an interest in her, and they joked around a lot. Even though she could mostly do things independently, he would come into her room and help her with things. She said that he changed her bedding after being incontinent. This confused her, she did not understand why he would do that kind of thing, and then show an interest in her. One time he helped her with a nightgown that had a string on the back at the neckline. He tied the string and then kissed her on the neck without saying anything. This surprised and confused her about the interaction.

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Another time, as she put on her socks, Staff I was in the room. He offered to put one on, held her foot, stoked it and said "you have beautiful feet," then kissed her foot. She felt surprised by this but no one said anything and he acted like it was no big deal. She said used a wheelchair on the night that Staff I took her to his car. He wheeled her down to the area with trees, in the dark and pouring down rain. He laughed and joked with her until they got into the car. Once inside, his mood changed, he pulled a bottle of Crown Royal (alcohol) out from under his car seat and told her that he started drinking it at the beginning of the day. She said that he then put on some loud, "dirty" music. She said that he shared with her that he made and recorded his own music. She reported the lyrics as violent. Due to the darkness, she did not see his penis outside his pants. With his right hand he grabbed the back of her neck, pulled her hair, and shoved her head into his lap. She said that while she had his penis in her mouth, she could see a bright light coming from his phone in his left hand. She knew that meant that he videotaped her. Resident #1 said that after the incident, she went directly to her room and did not talk to anyone. She remembered that Staff I did not work for several days after the incident. Then they never talked about the event.

Resident #1's Clinical Physician's Orders reviewed on 11/14/23 at 10:14 AM included the following medications that could cause drowsiness:
a. Dilaudid (opioid pain medication) 2 milligrams (mg) every 4 hours as needed for pain
b. Lorazepam (antianxiety medication) 0.5 mg every 12 hours as needed
c. Trazodone (antidepressant used for sleep) 100

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mg at bedtime
d. Morphine (opioid pain medication) sulfate 30 mg twice a day.

A review of the weather history indicated that it rained with showers on 10/12/23 in the area.

Timesheet records show that Staff I worked on 10/12/23 from 6:02 PM - 10:43 PM.

Resident #1's text messages revealed that she sent Staff I a message at 9:57 PM on 10/12/23, then again at 10:58 PM in which she reminded him to send the video. He then sent the video, and on 10/13/23 at 7:42 PM he sent a message to her asking "how are you?". She did not respond to that message until 10/15/23 at 8:16 PM and said that she was not feeling well. On the 16th at 5:24 PM she offered to Cash App some money to him if he would buy her some cigarettes. At 10:38 PM a transfer of $10.00 went from Resident #1's account to Staff I's account, with another $21.00 sent on 10/18/23 at 2:03 PM. Resident #1's Cash App included a transaction on 10/22/23, of $22.00 sent to Staff F's, CNA, account.

On 11/16/23 at 8:56 AM Staff F admitted that she accepted money from Resident #1's Cash App to buy her some pop and chips. She said she knew it was not right.

On 11/8/23 at 10:48 AM, Staff A, Dietary Aide (DA), said that on the evening of 10/23/23 while she waited outside the facility for a ride after her shift, she sat on the patio with Resident #1. At that time, Resident #1 told her that Staff I bought her cigarettes. He would take her phone and transfer money into his own Cash App. She told

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her that he took her to his car one night and forced her to perform oral sex. She said that they were drinking alcohol and she did not want anyone to know about it. Staff F, Nurse Aide (NA), then stopped over and entered the conversation when Resident #1 told them that she had a video, but her phone needed to charge, so she could not show them. She described Resident #1 as trembling when she told them the story. Staff A said Resident #1 reported being afraid of what he might do if he knew she told anyone.

On 11/8/23 at 10:32 AM, Staff F said that on the evening of 10/23/23, while Resident #1 sat outside with Staff A, she approached them. Staff A looked at Resident #1 and asked "can I tell her?" Resident #1 shook her head "yes" and Staff A proceeded to tell her that Staff I sent her a video of himself masturbating. They agreed that they needed to report that to the Administrator. The next morning around 10:00 AM they both went in the next morning.

On 11/8/23 at 2:18 PM, the Administrator said that on 10/24/23, a couple of staff members told her that there was a situation with Staff I buying cigarettes for Resident #1, and that he used a Cash App on his phone. The Administrator said that she had Staff I come into her office that morning. He showed her the Cash App receipt on his phone for $10.00, and she suspended him from the building. When asked about the allegations of sex, the Administrator said that she confronted Resident #1 about providing sexual favors for cigarettes, but she denied it. She said that Staff I denied any sexual activity with Resident #1. He acknowledged that he would take her out to smoke but denied anything sexual. The Administrator said that Resident #1 wrote a

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letter stating that it was false and denied everything.

A hand-written note dated 10/24/23 at 8:52 AM, signed by Resident #1, indicated that the Administrator had confronted Resident #1 and accused her of providing sexual favors for cigarettes. Resident #1 reported being very upset by the allegations, and that she would never do anything so vile. She denied the allegations and the hand-written note lacked any reference to forced sexual acts.

On 10/24/23, the Regional MDS Coordinator (RC) added the following to Resident #1's Care Plan;
a. Staff caught Resident #1 outside in front of the building smoking.
b. Resident #1 had a behavior problem that involved manipulating staff, and making up stories that did not happened.

According to a Social Services Behavior History Evaluation dated 9/26/23 at 9:28 AM, Resident #1 did not make accusatory statements, described her as not worried, not anxious, not tearful, and did not have mood swings.

The follow-up Behavioral History completed on 10/10/23 at 1:58 PM resulted with the same conclusion.

On 11/13/23 at 8:47 AM the RC described her role as to oversee the MDS coordination for the facilities in the region. She said that she would be in the building about once a week but she would mainly spend her time with the MDS staff and leadership, resulting in her not being very familiar with the residents. She said that they talked about the residents in morning meetings. She

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acknowledged that she made the addition to Resident #1's Care Plan on 10/24/23. She explained it as a group effort to include that area of focus, based on Resident #1 sharing and using snacks to her advantage with staff. She said that Resident #1 told a story about how the hospital tied her down and she received the wound on her wrist from that, but she did not know about examples of any made-up stories while at the facility. When asked about allegations against Staff I, she said she did not know anything about that staff member, or allegations of abuse. She maintained that in their leadership meeting when she changed the care plan on 10/24/23, they did not talk about the abuse allegations

On 11/13/23 at 9:00, Staff D, Registered Nurse (RN), said that when RC came to the morning leadership meeting that she attended on 10/24/23, they discussed Resident #1's abuse allegations about Staff I.

On 11/6/23 at 1:33 PM, Staff J, NA, said that Resident #1 would spent most of her days in her room sleeping, then she came out in the evenings and nights. In the days leading up to her discharge, she started coming out more in the evenings and interacted with others. She would ask to go outside even after dark and/or cold out and sit on the bench on the porch. She could not go too far with her walker before getting fatigued.

On 11/6/23 at 1:38 PM Staff K, CNA, said that Resident #1 only went out at night and would sit out there for long periods of time. She sat with Staff I for more than an hour. One-night Staff I came back inside after 11:00 PM and his shift ended at 10:00 PM.

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On 11/6/23 at 3:49 PM, Staff L, CNA, said that she witnessed Staff I spending time with Resident #1 outside on the patio. They would be out there for over an hour.

On 11/8/23 at 11:55 AM, Staff M, CNA, said she only worked at the facility a couple of times and she would never go back. She said that the last day she worked at the facility, the Administrator yelled at Resident #1, giving her only 30 minutes to pack up her room and leave. She described Resident #1 as crying and shaking. She said that Resident #1 told her that Staff I raped her and he took a video of it. While Staff M helped Resident #1 pack her things on 10/25/23, the Administrator and her yelled at each other. Resident #1 appeared very upset.

On 11/8/23 at 8:17 AM, Staff E, Registered Nurse (RN), said that she worked the overnight shifts. She described Resident #1 as good with the staff and the other residents. Resident #1 had food items delivered to the facility, she was kind, and would share her snacks. She would often see her out on the patio. Staff I would work until 10:00 PM and then spend time with Resident #1 outside.

On 11/8/23 at 3:30 PM, Staff Q, CNA, said that she did not see any interactions between Resident #1 and Staff I. She did report that she saw the video of him masturbating. Staff Q said that she worked with him before. She described him as very invasive and would get into "your bubble." She said that Resident #1 told her about Staff I forcing her head in his lap to perform oral sex and that he recorded it.

On 11/9/23 at 8:50 AM, Staff I said that on 10/24/23, his schedule had him working a 6a-6p

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shift. At around 9:00 AM, the Administrator called him into her office. She asked him if he purchased cigarettes for a resident, he told her that he did and showed her the Cash App. He said "the lady sent me money and I bought her cigarettes." The Administrator asked him if he ever took Resident #1 in his car to go purchase cigarettes and he told her that he did not. He said he chose to leave the facility on 10/24/23 because he would not feel comfortable working there anymore. He said that he went to a sister facility and finished up a shift that same day. He denied having any kind of relationship with Resident #1 and said that he would sit with her a little bit on the patio. He denied sending her any messages and said that he did not feel he did anything wrong with accepting her money for the purchase of cigarettes. Staff I went on to say that he worked in different states and did not have a problem with buying things for residents. Staff I said that he did not spend much time with Resident #1. When asked if he thought that she had the wrong impression about their relationship, Staff I asked what the questions were about and did not understand the reason for the interview. He maintained that the Administrator did not bring up or ask about any sexual interactions between him and Resident #1. Staff I then chuckled and said that he worked as an intelligence officer and learned to record things. He thought that he may have a recording of the interaction between himself and the Administrator. He said "I am keeping my magnetism, I can overcome obstacles ... I am a stellar worker." He said that the company begged him to work other shifts since 10/24/23. He mentioned three other facilities that he completed shifts after the 24th. He did not understand that if they thought he did something wrong, why they

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allowed him to continue to work for the company? He reported feeling upset and described the allegations as preposterous.

On 11/9/23 at 5:40 PM, Staff C, CNA, said that Resident #1 went out at night and she knew when what time she could her pain pills. Resident #1 would go out and sit on the patio for hours, Staff C did not know what she did out there for so long, "I got work to do." She said that Staff I would hang around outside long after his shift ended at 10:00 PM. Sometimes he slept in his red car overnight in the parking lot at the facility. She described Staff I as "flirty" with some staff members.

On 11/14/23 at 9:00 AM the Regional Director of Nursing said that their leadership team had a "rapid response" phone call regarding the concern with Resident #1 on 10/24/23. She said that most of the conversation was related to the concern about money exchange from resident to staff. The conversation included very little discussion regarding sexual innuendos. She said that the Administrator conveyed to them that Staff I only made a motion that simulated masturbation. The meeting did not include anything about allegations of forced sexual activity.

On 11/14/23 at 2:50 PM the Regional Manager said the rapid response team did not get all the information, or accurate information from the Administrator to determine the next steps. She said that had they known all the details, they would have made different decisions.

A review of the personal file for Staff I included a Corrective Action Form dated 10/25/23. The form

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F 600	Continued From page 13 described the infraction on 10/23/23 as a resident reported that she transferred money to him on a mobile app to purchase cigarettes for her. He received a verbal warning not to take money for any reason from a resident. The verbal warning did not include any references to a sexual abuse allegation. According to an annual facility survey report dated 10/19/22, Staff I recorded a resident without her consent or knowledge. His personal file lacked a corrective action form or any indication that the facility addressed that incident with him. Staff I's timesheet showed that he continued to work with vulnerable elderly population in their facilities on 10/24/23 from 2:04 PM - 7:02 PM, 10/28/23 from 10:19 PM - 6:14 AM, and on 10/30/23 at 10:01 PM - 6:00 AM. According to the Dependent Adult Abuse policy dated November 2019 directed that all residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included prohibiting nursing staff from taking pictures that result in person degradation, including the taking or use of photographs or recording in any manner.	F 600		
F 607 SS=G	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		

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F 607	Continued From page 14 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and policy review the facility failed to prevent retribution to a resident and a staff member for 1 of 3 residents (Resident #1). Resident #1 reported that a male Certified Nurse Aide (CNA) sexually abused her. After the facility learned of the allegations on 10/24/23, they discharged Resident #1 to a homeless shelter on 10/25/23 with only approximately 30 minutes to pack. In addition, Staff P reported that the facility suspended her after she confronted the Administrator regarding the need to report the abuse. The facility suspended Staff Q from work for not reporting abuse within 2 hours after she learned about the	F 607		

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allegation. At the time she reported the allegation, the facility already knew from other staff. The facility asked her to share information related to the abuse to speed up their investigation so she could return to work sooner. Due to the facility's treatment of Resident #1 after the facility learned of the allegation of abuse, caused Resident #1 to become afraid and cry during an exchange of yelling between her and the Administrator.

Findings include:

Resident #1's Minimum Data Set (MDS) assessment dated 9/24/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment reflected that Resident #1 did not have behaviors. Resident #1 required limited assistance from one person for transfers, dressing, toilet use, and personal hygiene. The MDS listed Resident #1 as frequently incontinent of urine and always continent of bowel. The MDS included diagnoses of disorder of the kidney, heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and malignant neoplasm of upper lobe (lung cancer). The assessment indicated that Resident #1 almost always had pain.

The Care Plan included the following Focuses dated 10/3/23:
a. Resident #1 planned to rehab to home. The Goal listed that Resident #1 would transition back to the community.
b. Activities of daily living (ADLs). The Interventions directed that Resident #1 could independently provide her own hygiene, toilet use, and transfers.

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c. Resident #1 is independent in the facility. The Interventions reflected that Resident #1 used a front wheel walker.

On 11/6/23 at 2:13 PM, Resident #1 said that when she reported her abuse to a couple of staff members, somehow, they twisted the story around. Due to this she did not trust anyone at the facility any more. She said that the Administrator came into her room one day, yelling, and told her that she had to leave because the staff reported that she provided sexual favors for cigarettes. Resident #1 said that staff took her outside to have cigarettes, and she shared with a couple of them. Staff I sexually attacked her. She could not remember the date when Staff I took her to his car and made her perform oral sex on him. Resident #1 said when planning her discharge, the Social Worker (SW) told her that she planned to help her find housing so her son could come and live with her. The Women's and Children's Shelter was an option but her son was too old to go there. She said she felt like the facility kicked her out because of the lies told about her.

On 11/8/23 at 2:18 PM, the Administrator said that on 10/24/23, a couple of staff members told her about a situation with Staff I buying cigarettes for Resident #1, and that he used a Cash App on his phone. The Administrator said that she had Staff I come into her office that morning. He showed her the Cash App receipt on his phone for $10.00, and she suspended him from the building. When asked about the allegations of sex, the Administrator said that she confronted Resident #1 about providing sexual favors for cigarettes, but she denied it. She said that Staff I denied any sexual activity with Resident #1. He

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acknowledged that he would take her out to smoke but denied anything sexual. The Administrator said that Resident #1 wrote a letter stating that it was false and denied everything.

A hand-written note dated 10/24/23 at 8:52 AM, signed by Resident #1, indicated that the Administrator confronted Resident #1 and accused her of providing sexual favors for cigarettes. Resident #1 reported being very upset by the allegations, and that she would never do anything so vile. She denied the allegations and the hand-written note lacked any reference to forced sexual acts.

On 11/14/23 at 2:15 PM, the Police Officer who interviewed Resident #1 on 11/1/23 described her as forthcoming but very embarrassed when she came in to the report abuse. He said that when she tried to describe what happened, she stumbled and had difficulty describing the sexual act. She mentioned being heavily medicated while at the facility and could not give consent. She told the officer that Staff I sent her a sexually explicit video of himself.

The Encounter Note dated 10/24/23 at 12:00 AM signed by the Advanced Registered Nurse Practitioner (NP) on 10/26/23 at 8:08 PM reflected that Resident #1 saw the NP on 10/24/23. At that time, Resident #1 cried and stated that she had a lot of pain. They discussed getting her an appointment with the pain clinic. Resident #1 told her about her leaving the facility in 1-2 days, as the staff falsely accused her of being inappropriate with a staff member. She planned to leave and be at the homeless shelter for 6 months. The provider received a call from the facility on 10/25/23 indicating that day they

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planned to discharge Resident #1. The NP recommended to follow-up for medication refills in six months and she would provide a 7-day supply of medications.

On 10/24/23, the Regional MDS Coordinator (RC) added the following to Resident #1's Care Plan:
a. Staff caught Resident #1 outside in front of the building smoking.
b. Resident #1 had a behavior problem that involved manipulating staff, and making up stories that did not happened.

According to a Social Services Behavior History Evaluation dated 9/26/23 at 9:28 AM, Resident #1 did not make accusatory statements, described her as not worried, not anxious, not tearful, and did not have mood swings.

The follow-up Behavioral History completed on 10/10/23 at 1:58 PM resulted with the same conclusion

On 11/13/23 at 8:47 AM the RC described her role as to oversee the MDS coordination for the facilities in the region. She said that she would be in the building about once a week but she would mainly spend her time with the MDS staff and leadership, resulting in her not being very familiar with the residents. She said that they talked about the residents in morning meetings. She acknowledged that she made the addition to Resident #1's Care Plan on 10/24/23. She explained it as a group effort to include that area of focus, based on Resident #1 sharing and using snacks to her advantage with staff. She said that Resident #1 told a story about how the hospital tied her down and she received the wound on her wrist from that, but she did not know about

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examples of any made-up stories while at the facility. When asked about allegations against Staff I, she said she did not know anything about that staff member, or allegations of abuse. She maintained that in their leadership meeting when she changed the care plan on 10/24/23, they did not talk about the abuse allegations.

On 11/13/23 at 9:00, Staff D, Registered Nurse (RN), said that when RC came to the morning leadership meeting that she attended on 10/24/23, they discussed Resident #1's abuse allegations about Staff I.

On 11/9/23 at 12:15 PM, Staff H, Housekeeping Staff, said that on the morning of 10/25/23, she loaded up the remainder of Resident #1's belongings in her personal vehicle and drove them to the shelter. The transportation provider came with a very small car and they could not get all her items in that vehicle. As she helped Resident #1 pack her things, she appeared very angry, crying, and said that she felt the facility kicked her out. She kept asking to speak to someone above the Administrator about what was happening. She got to the shelter with Resident #1 items at about 1:30 PM that day.

On 11/8/23 at 11:12 AM the Social Worker (SW) reported the transfer of Resident #1 to the homeless shelter as appropriate as she came from there per her lifestyle choice. Resident #1 always had a goal to discharge and reunite with her son. When asked if she told the staff at the shelter the level of need before sending Resident #1 to the shelter, she replied "yes and no." The SW continued by expressing Resident #1's "behaviors" related to impulsivity and lack of follow through. When inquired about Resident

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#1's level of medical needs, she responded that therapy told her that Resident #1 could use a walker. The Regional Director of Nursing arranged to get her a walker to take with her but she wanted to get out. She said that after Resident #1's admission to the shelter, she called 911 that night, but she did not know what happened after that. She denied knowing anything about Staff I or cigarettes. She maintained that she had Resident #1's permission to make the arrangements to go to the shelter.

On 11/9/23 at 10:45 AM during a telephone call, the SW said that the Administrator reached out to the homeless shelter to ask about admitting her. Afterwards, she made the transportation arrangements. She said that she got a call from a very upset shelter representative the next day about Resident #1 and said that she "faked a heart attack." They sent her to the hospital, and they could see what she was like. The SW told her that they could not take her back because of her behaviors and manipulation. She met all her goals and she wanted to go to there. When questioned about if she sent Resident #1's medical information with her, she replied no, as a homeless person off the street did not come into a shelter with their medical diagnosis information. As that is what they do.

On 11/13/23 at 3:00 PM the SW said that they put a discharge checklist on the wall in her office so they can go down the list and make sure they are hitting on the planning points. She said the 24-hour notice challenged her with the need to get the transportation. The SW had a conversation with Resident #1 about discharge on Friday or Monday. She questioned about he

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being okay to discharge sooner as they had a 4-hour notice. Resident #1 reported she was fine with it, as it was better because then her sister did not have to come and get her.

A review of a voice recording from the transportation company, dated 10/25/23 at 7:28 AM, revealed that the SW called for a ride at that time without Resident #1 in the room with her. When the SW made the arrangements, she chose the 4-hour pick-up time and said "that works for me." They finalized the arrangements and once the company found a driver, they would notify them of the time of arrival.

On 11/15/23 at 8:00 AM Staff N, Registered Nurse (RN), said early that morning, Resident #1 went around to say good bye to other residents and staff. Later that morning when she found out that she only had a half hour to get everything together and packed she started to cry. Resident #1 expressed that she felt like the facility kicked her out. Staff N said that she understood that they had a plan for discharge but it came very abruptly. Staff N reported that she had concerns that Resident #1 went to a homeless shelter without nursing services especially when she needed monitoring as the provider just changed her hypertension.

On 11/9/23 at 8:15 AM Shelter Staff 1 (SS1) called back and said that the transportation company just dropped Resident #1 off at the shelter with no paperwork and no phone call. She said they did not typically accept residents from a hospital or nursing home that way. They need to know what level of care the resident required so they can determine if they are appropriate or if they can handle them. On 10/25/23 around 1:00

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PM the transportation company dropped her off. Initially, the cab driver dropped her off at a safe house intended for domestic violence victims. The driver did not know what to do with her when they would not accept her there, so, they called the facility, who told them to take her to the homeless shelter. SS1 did the intake herself and then she had to leave early that day. Her daughter worked there in the afternoon and she called 911 due to Resident #1 shaking, falling, and unstable around 4:00 PM in the afternoon. At 6:15 AM on 10/26/23 the hospital returned her soiled back at the shelter. They got her a room to clean up and she talked to a friend on the phone. Around 11:00 AM on the 10/26/23, Resident #1's friend came and picked her up. She said she did not know what happened from there. They try not to get too involved in the resident's lives or situations once they leave the shelter. She said the facility made her very upset for just dropping off Resident #1 without first having a consultation on her level of need. She explained that "we have children here" and do not have nursing staff. She did call and talk to the SW who said that she did not make the arrangements and indicated that they would not take Resident #1 back because she made allegations against staff.

On 11/13/23 at 7:26 AM SS1 that she knew for a fact that no one talked to Shelter Staff 2 (SS2), before Resident #1 showed up at their door. She said that when they get residents from a facility or hospital, they put them on a list. When Resident #1 showed up she checked the list, which did not include her. SS2 called back to the facility the next day and talked to the SW but not before. SS1 was very sure of that because she is the manager, they all stay on top of who is calling and who is on the list. When Resident #1 showed up

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at their door, she told them that she did not know where they sent her. She said that they will never do business with that facility ever again or with "that SW lady."

On 11/13/23 at 2:32 PM SS2 said that the first day she talked to anyone at the facility was the day that Resident #1 showed up at their door. They write down their notes or document on the computer and they have no notes that someone contacted them regarding Resident #1 coming there. Resident #1 was at the door, concerned about the driver because he was on the phone with the facility. Originally, he went to the wrong place first and then did not know what to do with her things. Then the SW called back just after Resident #1 got there and SS2 told her that Resident #1 could barely walk, shook, and had shortness of breath. Resident #1 worried about holding up the driver. SS2 recalled her surprise when they started unloading all of Resident #1's things and said that they could only allow 2 bags. SS2 said that Resident #1 he had a TV and everything. SS2 talked to the SW on the phone telling her about Resident #1 not stable and she did not know if they could take care of her there. The SW told her that because of her behaviors they could not take her back. She told the SW that they did not know about her coming, the SW responded that she was sure someone took care of that. SS2 started the intake and later called non-emergent care to pick her up because she seemed so unstable. She did come with some medications, they are responsible for taking them on their own. SS2 said if Resident #1 stayed there before, it was a long time ago because she did not have a record of her being there.

On 11/13/23 at 10:30 AM Staff P, Former Office

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Manager, said that she no longer worked at the facility. She felt that the administration was looking for some reason to terminate her because she questioned them on reporting the events to the proper authorities. Staff P said that she heard about the allegations of abuse later in the day on 10/24/23 and sent a text to the Regional Manager at 5:30 PM, expressing that they should report the event. She then she got a call back from corporate that Resident #1 recanted the allegations so they did not think they needed to report it. She said that when she came into work on the 25th, her office had been in shambles because they were looking through for missing orders. They suspended her because of the missing orders.

On 11/15/23 at 2:20 PM Staff Q, CNA, explained that the facility suspended her from working pending investigation, because she did not report allegations of abuse within 2 hours. When she learned about the incident, the facility already knew about the incident from someone else. She said that the facility told her that their investigation could speed up if she could provide a copy of any video or text messages that exchanged between Resident #1 and Staff I.

On 11/14/23 at 9:00 AM the Regional Director of Nursing (RDON) said that she assisted with Resident #1's discharge. She maintained that she gave her a list of her medication, diagnoses, Care Plan, and a summary of her stay. She said that while she went through the discharge with Resident #1, the Administrator poked her head in the room. Resident #1 called her a "bitch" but did not say why the Administrator upset her. She said that Resident #1 did not share any concerns with her and she had offered her other avenues to file

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CORRECTIONVILLE SPECIALTY CARE	1116 EAST HIGHWAY 20 CORRECTIONVILLE, IA 51016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 25 grievance but she was not interested. She maintained that they planned the discharge since 10/9/23. Resident #1 knew about it and agreed to the transfer. She said that as they packed things up, Resident #1 said that she thought that she could only have 3 bags of items at the shelter, but the SW disagreed with her, and said that they would take all her things. The Dependent Adult Abuse Protocols dated November 2019, described the procedure for keeping resident free from abuse include screening and training employees, protection of residents and prevention, identification, investigation and timely reporting of abuse, neglect, mistreatment, and misappropriation of proper, without the fear of recrimination or intimidation.	F 607		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides	F 609		

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for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review, staff, and resident interviews, the facility failed to report allegations of abuse within 2 hours for 1 of 3 residents reviewed (Resident #1). Resident #1 reported to staff on 10/23/23 that a staff member sexually abused her, in addition to transferring money from her account to staff. The facility did not report the incident to the appropriate authorities until the evening of 10/24/23.

Findings include:

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of 10/23/23 on 11/9/23 at 4:00 PM. The facility removed the IJ and decreased the scope to a "D" on 11/13/23 with the following actions:

a. The facility provided the following education:
i. Dependent adult abuse and sexual abuse including consensual vs. non-consensual education and the need to immediately report the allegation on 11/10/23.
ii. Spotting Signs of Elder Abuse to include caretaker boundaries on 11/10/23.

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iii. The facility's expectations regarding purchasing personal items for residents on 11/10/23.
iv. Discharge/transfer policy, highlighted resident-initiated discharge including meeting the needs of the resident welfare on 11/10/23.
v. Supervision of outdoor visits on 11/13/23.
b. The facility interviewed residents on all the alert and oriented residents on 11/11/23. In addition, the facility audited the remaining residents for any non-verbal signs of abuse.
c. The facility updated the Agency Orientation Checklist to include Abuse Protocol to highlight dependent adult abuse reporting policy and professional boundaries.

Resident #1's Minimum Data Set (MDS) assessment dated 9/24/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment reflected that Resident #1 did not have behaviors. Resident #1 required limited assistance from one person for transfers, dressing, toilet use, and personal hygiene. The MDS listed Resident #1 as frequently incontinent of urine and always continent of bowel. The MDS included diagnoses of disorder of the kidney, heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and malignant neoplasm of upper lobe (lung cancer). The assessment indicated that Resident #1 almost always had pain.

The Care Plan included the following Focuses dated 10/3/23:
a. Resident #1 planned to rehab to home. The Goal listed that Resident #1 would transition back to the community.

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b. Activities of daily living (ADLs). The Interventions directed that Resident #1 could independently provide her own hygiene, toilet use, and transfers.
c. Resident #1 is independent in the facility. The Interventions reflected that Resident #1 used a front wheel walker.

On 11/8/23 at 10:48 AM, Staff A, Dietary Aide (DA), said that on the evening of 10/23/23 while she waited outside of the facility for a ride after her shift and sat with Resident #1 on the patio. Resident #1 told her that Staff I, Certified Nurse Aide (CNA), bought her cigarettes, then he took her phone and transferred money into his own Cash App. After this, Resident #1 told Staff A that he took her to his car one night and forced her to perform oral sex on him. Resident #1 said that they were drinking alcohol and she did not want anyone to know about it. Staff F, Nurse Aide (NA), then stopped over and entered the conversation when Resident #1 told them that she had a video from Staff I, but she needed to charge her phone, so she could not show them. She said that Resident #1 trembled when she told them the story and expressed fear of what he might do if he knew she told anyone.

On 11/8/23 at 10:32 AM, Staff F said that on the evening of 10/23, Resident #1 sat outside with Staff A and when she approached, Staff A looked at her and asked "can I tell her?" Resident #1 shook her head "yes" and Staff A proceeded to tell her that Staff I sent her a video of himself masturbating. They agreed that they needed to report this to the Administrator. The next morning at around 10:00 AM they both went in to talk to the Administrator.

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On 11/8/23 at 2:18 PM, the Administrator said that on 10/24/23, a couple of staff members told her about a situation with Staff I buying cigarettes for Resident #1, and that he used a Cash App on his phone. The Administrator said that she had Staff I come into her office that morning. He showed her the Cash App receipt on his phone for $10.00, and she suspended him from the building. When asked about the allegations of sex, the Administrator said that she confronted Resident #1 about providing sexual favors for cigarettes, but she denied it. She said that Staff I denied any sexual activity with Resident #1. He acknowledged that he would take her out to smoke but denied anything sexual. The Administrator said that Resident #1 wrote a letter stating that it was false and denied everything.

A hand-written note dated 10/24/23 at 8:52 AM, signed by Resident #1, indicated that the Administrator confronted Resident #1 and accused her of providing sexual favors for cigarettes. Resident #1 reported being very upset by the allegations, and that she would never do anything so vile. She denied the allegations and the hand-written note lacked any reference to forced sexual acts.

The complaint unit from The Department of Inspections, Appeals, and Licensing (DIAL) confirmed in an email on 11/28/23 that the facility reported the incident on 10/24/23 at 9:35 PM.

The Sheriff's Office Incident Report dated 11/1/23 at 6:22 PM, reflected that a Sheriff's Office Representative interviewed Resident #1 about allegations of sexual abuse. She said that during her time as a resident in the nursing home, Staff I, CNA, sexually abused her. She stated that

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while taking care of her, Staff I would touch and kiss her inappropriately on the back of the neck and on her feet. She said that 2-3 weeks prior to her discharge, she went outside the facility to have a cigarette and it had been raining. Staff I asked if she would like to have her cigarette in his car and she agreed. He wheeled her to the car and while in the vehicle, he forced her to perform oral sex on him. She described the vehicle as a small red car parked by the row of trees near the highway.

On 11/14/23 at 2:15 PM, the Police Officer who interviewed Resident #1 on 11/1/23 described her as forthcoming but very embarrassed when she came in to the report abuse. He said that when she tried to describe what happened, she stumbled and had difficulty describing the sexual act. She mentioned being heavily medicated while at the facility and could not give consent. She told the officer that Staff I sent her a sexually explicit video of himself.

On 11/13/23 at 10:30 AM Staff P, Former Office Manager, said that she no longer worked at the facility. She felt that the administration was looking for some reason to terminate her because she questioned them on reporting the events to the proper authorities. Staff P said that she heard about the allegations of abuse later in the day on 10/24/23 and sent a text to the Regional Manager at 5:30 PM, expressing that they should report the event. She then she got a call back from corporate that Resident #1 recanted the allegations so they did not think they needed to report it. She said that when she came into work on the 25th, her office had been in shambles because they were looking through for missing orders. They suspended her because of the

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F 609	Continued From page 31 missing orders. On 11/14/23 at 9:00 AM the Regional Director of Nursing said that their leadership team had a "rapid response" phone call regarding the concern with Resident #1 on 10/24/23. She said that most of the conversation was related to the concern about money exchange from resident to staff. The conversation included very little discussion regarding sexual innuendos. She said that the Administrator conveyed to them that Staff I only made a motion that simulated masturbation. The meeting did not include anything about allegations of forced sexual activity. On 11/14/23 at 2:50 PM the Regional Manager said the rapid response team did not get all the information, or accurate information from the Administrator to determine the next steps. She said that had they known all the details, they would have made different decisions. According to the facility policy titled; Mandatory Reporting Abuse Investigation dated November 2019. All allegations of resident abuse need reported immediately. Administrator or his/her designee will designate a member of management to investigate the alleged incident to include: review of assessment of resident injury, assess the resident for injury, provide notification to primary care provider, and attempt to obtain witness statements (oral and/or written) from all known witnesses. The facility will establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination (blame) or intimidation.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation	F 610		

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F 610	Continued From page 32 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews with residents, staff and law enforcement, record review and policy review the facility failed to adequately investigate allegations of abuse for 1 of 3 residents reviewed (Resident #1). After Resident #1 reported allegations of sexual and financial abuse, the administration only addressed the exchange of money but minimized and failed to fully investigate the allegations of sexual abuse. Findings include: The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of 10/23/23 on 11/9/23 at 4:00 PM. The facility removed the IJ and decreased the scope to a "D" on 11/13/23 with the following actions:	F 610		

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a. The facility provided the following education:
i. Dependent adult abuse and sexual abuse including consensual vs. non-consensual education and the need to immediately report the allegation on 11/10/23.
ii. Spotting Signs of Elder Abuse to include caretaker boundaries on 11/10/23.
iii. The facility's expectations regarding purchasing personal items for residents on 11/10/23.
iv. Discharge/transfer policy, highlighted resident-initiated discharge including meeting the needs of the resident welfare on 11/10/23.
v. Supervision of outdoor visits on 11/13/23.
b. The facility interviewed residents on all the alert and oriented residents on 11/11/23. In addition, the facility audited the remaining residents for any non-verbal signs of abuse.
c. The facility updated the Agency Orientation Checklist to include Abuse Protocol to highlight dependent adult abuse reporting policy and professional boundaries.

Resident #1's Minimum Data Set (MDS) assessment dated 9/24/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment reflected that Resident #1 did not have behaviors. Resident #1 required limited assistance from one person for transfers, dressing, toilet use, and personal hygiene. The MDS listed Resident #1 as frequently incontinent of urine and always continent of bowel. The MDS included diagnoses of disorder of the kidney, heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and malignant neoplasm of upper lobe (lung cancer). The assessment

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indicated that Resident #1 almost always had pain.

The Care Plan included the following Focuses dated 10/3/23:
a. Resident #1 planned to rehab to home. The Goal listed that Resident #1 would transition back to the community.
b. Activities of daily living (ADLs). The Interventions directed that Resident #1 could independently provide her own hygiene, toilet use, and transfers.
c. Resident #1 is independent in the facility. The Interventions reflected that Resident #1 used a front wheel walker.

On 11/8/23 at 10:48 AM, Staff A, Dietary Aide (DA), said that on the evening of 10/23/23 while she waited outside of the facility for a ride after her shift and sat with Resident #1 on the patio. Resident #1 told her that Staff I, Certified Nurse Aide (CNA), bought her cigarettes, then he took her phone and transferred money into his own Cash App. After this, Resident #1 told Staff A that he took her to his car one night and forced her to perform oral sex on him. Resident #1 said that they were drinking alcohol and she did not want anyone to know about it. Staff F, Nurse Aide (NA), then stopped over and entered the conversation when Resident #1 told them that she had a video from Staff I, but she needed to charge her phone, so she could not show them. She said that Resident #1 trembled when she told them the story and expressed fear of what he might do if he knew she told anyone.

On 11/8/23 at 10:32 AM, Staff F said that on the evening of 10/23, Resident #1 sat outside with Staff A and when she approached, Staff A looked

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at her and asked "can I tell her?" Resident #1 shook her head "yes" and Staff A proceeded to tell her that Staff I sent her a video of himself masturbating. They agreed that they needed to report this to the Administrator. The next morning at around 10:00 AM they both went in to talk to the Administrator.

On 11/6/23 at 2:13 PM, Resident #1 said that when she reported her abuse to a couple of staff members, somehow, they twisted the story around. Due to this she did not trust anyone at the facility any more. She said that the Administrator came into her room one day, yelling, and told her that she had to leave because the staff reported that she provided sexual favors for cigarettes. Resident #1 said that staff took her outside to have cigarettes, and she shared with a couple of them. Staff I sexually attacked her. She could not remember the date when Staff I took her to his car and made her perform oral sex on him. She said that he treated her nice and spent time with her. She thought that she may have gave him the wrong impression when she sent him texts. He then sent her a video of him pleasuring himself.

On 11/8/23 at 2:18 PM, the Administrator said that on 10/24/23, a couple of staff members told her about a situation with Staff I buying cigarettes for Resident #1, and that he used a Cash App on his phone. The Administrator said that she had Staff I come into her office that morning. He showed her the Cash App receipt on his phone for $10.00, and she suspended him from the building. When asked about the allegations of sex, the Administrator said that she confronted Resident #1 about providing sexual favors for cigarettes, but she denied it. She said that Staff I

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denied any sexual activity with Resident #1. He acknowledged that he would take her out to smoke but denied anything sexual. The Administrator said that Resident #1 wrote a letter stating that it was false and denied everything.

A hand-written note dated 10/24/23 at 8:52 AM, signed by Resident #1, indicated that the Administrator confronted Resident #1 and accused her of providing sexual favors for cigarettes. Resident #1 reported being very upset by the allegations, and that she would never do anything so vile. She denied the allegations and the hand-written note lacked any reference to forced sexual acts.

According to an untitled and undated facility investigation, two staff members reported to the Administrator that Resident #1 voiced concerns about Staff I. She indicated that the concerns were related to the purchase of cigarettes and when Resident #1 went to Staff I's car to get cigarettes, he made a gesture of oral sex while outside his car. When asked about the incident, Resident #1 denied that it occurred. The investigation indicated that Resident #1 had a history of making false stories and exaggerating events to gain attention. The Administrator separated Staff I from the facility and he admitted to purchasing cigarettes for Resident #1. The investigation statement included comments that the staff member who reported the abuse, had a history of making allegations against Staff I, and that many staff and residents at the facility had a history of making false allegations against African Americans. The statement indicated the facility contacted law enforcement on 10/24/23.

The investigation included an undated list of

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resident interviews, the investigation lacked staff interviews, and a resident assessment.

On 11/14/23 at 8:47 AM a representative from the sheriff's office went through the files to see if they got any calls from the facility on 10/24 or 10/25 about possible abuse with Resident #1 as the victim. The staff reported that they did not have any calls from the facility regarding abuse allegations.

On 11/9/23 at 8:50 AM, Staff I said that on 10/24/23, his schedule had him working a 6a-6p shift. At around 9:00 AM, the Administrator called him into her office. She asked him if he purchased cigarettes for a resident, he told her that he did and showed her the Cash App. He said "the lady sent me money and I bought her cigarettes." The Administrator asked him if he ever took Resident #1 in his car to go purchase cigarettes and he told her that he did not. He said he chose to leave the facility on 10/24/23 because he would not feel comfortable working there anymore. He said that he went to a sister facility and finished up a shift that same day. He denied having any kind of relationship with Resident #1 and said that he would sit with her a little bit on the patio. He denied sending her any messages and said that he did not feel he did anything wrong with accepting her money for the purchase of cigarettes. Staff I went on to say that he worked in different states and did not have a problem with buying things for residents. Staff I said that he did not spend much time with Resident #1. When asked if he thought that she had the wrong impression about their relationship, Staff I asked what the questions were about and did not understand the reason for the interview. He maintained that the

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Administrator did not bring up or ask about any sexual interactions between him and Resident #1. Staff I then chuckled and said that he worked as an intelligence officer and learned to record things. He thought that he may have a recording of the interaction between himself and the Administrator. He said "I am keeping my magnetism, I can overcome obstacles ... I am a stellar worker." He said that the company begged him to work other shifts since 10/24/23. He mentioned three other facilities that he completed shifts after the 24th. He did not understand that if they thought he did something wrong, why they allowed him to continue to work for the company? He reported feeling upset and described the allegations as preposterous.

On 11/14/23 at 9:00 AM the Regional Director of Nursing said that their leadership team had a "rapid response" phone call regarding the concern with Resident #1 on 10/24/23. She said that most of the conversation was related to the concern about money exchange from resident to staff. The conversation included very little discussion regarding sexual innuendos. She said that the Administrator conveyed to them that Staff I only made a motion that simulated masturbation. The meeting did not include anything about allegations of forced sexual activity.

On 11/14/23 at 2:50 PM the Regional Manager said the rapid response team did not get all the information, or accurate information from the Administrator to determine the next steps. She said that had they known all the details, they would have made different decisions.

The Dependent Adult Abuse Protocols November

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2019 instructed that upon receiving a report of an allegation of resident abuse, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, the facility will accomplish this by separating the employee accused of abuse from all residents through the following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility

According to the facility policy titled; Mandatory Reporting Abuse Investigation dated November 2019 directed that all allegations of resident abuse need reported immediately. Administrator or his/her designee will designate a member of management to investigate the alleged incident to include: review of assessment of resident injury, assess the resident for injury, provide notification to primary care provider, and attempt to obtain witness statements (oral and/or written) from all known witnesses. The facility will establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination (blame) or intimidation. The section titled Initial/Immediate Protection during Facility Investigation instructed that Upon receiving a report of an allegation of resident abuse, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. If this involves an allegation of abuse by an employee, the facility will accomplish this by separating the employee accused of abuse from all residents through the

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F 610	Continued From page 40 following or a combination of the following, if practicable: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility. Following completion of the facility investigation, if the facility concludes that the allegations of resident abuse are unfounded, the employee will be allowed to return to job duties involving resident contact, but the employee must maintain a separation and have no contact with the resident alleged to have been abused, by reassigning the accused employee to an area of the facility where no contact will be made between the accused employee and the resident alleged to have been abused. The facility must maintain the separation until the Department concludes its investigation and issues the written results of its investigation. Note: if the Department of Inspections, Appeals, and Licensing (DIAL) determines there was abuse (even though the facility did not substantiate the abuse), there is risk that DIAL could cite the facility with Immediate Jeopardy, for allowing an abuser to have access to other residents while the investigation continued.	F 610		
F 622 SS=J	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		

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because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, interviews with staff and residents and policy review the facility

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failed to meet a resident's needs related to adequately planned transfers for 1 of 3 residents reviewed (Resident #1). The facility discharged Resident #1 abruptly after allegations of abuse to a homeless shelter that did not know of her transfer. The homeless shelter did not have nurses on staff to meet her medical needs and they did not have any staff overnight. The homeless shelter transferred Resident #1 to the hospital as she could not safely remain in the homeless shelter. After arriving to the homeless shelter, Resident #1 began to stumble and fall.

Findings include:

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of 10/23/23 on 11/9/23 at 4:00 PM. The facility removed the IJ and decreased the scope to a "D" on 11/13/23 with the following actions:

a. The facility provided the following education:
i. Dependent adult abuse and sexual abuse including consensual vs. non-consensual education and the need to immediately report the allegation on 11/10/23.
ii. Spotting Signs of Elder Abuse to include caretaker boundaries on 11/10/23.
iii. The facility's expectations regarding purchasing personal items for residents on 11/10/23.
iv. Discharge/transfer policy, highlighted resident-initiated discharge including meeting the needs of the resident welfare on 11/10/23.
v. Supervision of outdoor visits on 11/13/23.
b. The facility interviewed residents on all the alert and oriented residents on 11/11/23. In addition, the facility audited the remaining residents for any non-verbal signs of abuse.

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c. The facility updated the Agency Orientation Checklist to include Abuse Protocol to highlight dependent adult abuse reporting policy and professional boundaries.

Resident #1's Minimum Data Set (MDS) assessment dated 9/24/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment reflected that Resident #1 did not have behaviors. Resident #1 required limited assistance from one person for transfers, dressing, toilet use, and personal hygiene. The MDS listed Resident #1 as frequently incontinent of urine and always continent of bowel. The MDS included diagnoses of disorder of the kidney, heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and malignant neoplasm of upper lobe (lung cancer). The assessment indicated that Resident #1 almost always had pain.

The Care Plan included the following Focuses dated 10/3/23:
a. Resident #1 planned to rehab to home. The Goal listed that Resident #1 would transition back to the community.
b. Activities of daily living (ADLs). The Interventions directed that Resident #1 could independently provide her own hygiene, toilet use, and transfers.
c. Resident #1 is independent in the facility. The Interventions reflected that Resident #1 used a front wheel walker.

On 11/6/23 at 2:13 PM, Resident #1 said that when she reported her abuse to a couple of staff members, somehow, they twisted the story

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around. Due to this she did not trust anyone at the facility any more. She said that the Administrator came into her room one day, yelling, and told her that she had to leave because the staff reported that she provided sexual favors for cigarettes. Resident #1 said that staff took her outside to have cigarettes, and she shared with a couple of them. Staff I sexually attacked her. She could not remember the date when Staff I took her to his car and made her perform oral sex on him. Resident #1 said when planning her discharge, the Social Worker (SW) told her that she planned to help her find housing so her son could come and live with her. The SW offerred a homeless shelter as option but her son could not go there due to his age. She said she felt like the facility kicked her out because of the lies told about her.

On 10/24/23, the Regional MDS Coordinator (RC) added the following to Resident #1's Care Plan:
a. Staff caught Resident #1 outside in front of the building smoking.
b. Resident #1 had a behavior problem that involved manipulating staff, and making up stories that did not happened.

According to a Social Services Behavior History Evaluation dated 9/26/23 at 9:28 AM, Resident #1 did not make accusatory statements, described her as not worried, not anxious, not tearful, and did not have mood swings.

The follow-up Behavioral History completed on 10/10/23 at 1:58 PM resulted with the same conclusion.

On 11/13/23 at 8:47 AM the RC described her role as to oversee the MDS coordination for the

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facilities in the region. She said that she would be in the building about once a week but she would mainly spend her time with the MDS staff and leadership, resulting in her not being very familiar with the residents. She said that they talked about the residents in morning meetings. She acknowledged that she made the addition to Resident #1's Care Plan on 10/24/23. She explained it as a group effort to include that area of focus, based on Resident #1 sharing and using snacks to her advantage with staff. She said that Resident #1 told a story about how the hospital tied her down and she received the wound on her wrist from that, but she did not know about examples of any made-up stories while at the facility. When asked about allegations against Staff I, she said she did not know anything about that staff member, or allegations of abuse. She maintained that in their leadership meeting when she changed the care plan on 10/24/23, they did not talk about the abuse allegations.

On 11/13/23 at 9:00, Staff D, Registered Nurse (RN), said that when RC came to the morning leadership meeting that she attended on 10/24/23, they discussed Resident #1's abuse allegations about Staff I.

On 11/8/23 at 11:12 AM the Social Worker (SW) reported the transfer of Resident #1 to the homeless shelter as appropriate as she came from there per her lifestyle choice. Resident #1 always had a goal to discharge and reunite with her son. When asked if she told the staff at the shelter the level of need before sending Resident #1 to the shelter, she replied "yes and no." The SW continued by expressing Resident #1's "behaviors" related to impulsivity and lack of follow through. When inquired about Resident

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#1's level of medical needs, she responded that therapy told her that Resident #1 could use a walker. The Regional Director of Nursing arranged to get her a walker to take with her but she wanted to get out. She said that after Resident #1's admission to the shelter, she called 911 that night, but she did not know what happened after that. She denied knowing anything about Staff I or cigarettes. She maintained that she had Resident #1's permission to make the arrangements to go to the shelter.

On 11/9/23 at 10:45 AM during a telephone call, the SW said that the Administrator reached out to the homeless shelter to ask about admitting her. Afterwards, she made the transportation arrangements. She said that she got a call from a very upset shelter representative the next day about Resident #1 and said that she "faked a heart attack." They sent her to the hospital, and they could see what she was like. The SW told her that they could not take her back because of her behaviors and manipulation. She met all her goals and she wanted to go to there. When questioned about if she sent Resident #1's medical information with her, she replied no, as a homeless person off the street did not come into a shelter with their medical diagnosis information. As that is what they do.

On 11/13/23 at 3:00 PM the SW said that they put a discharge checklist on the wall in her office so they can go down the list and make sure they are hitting on the planning points. She said the 24-hour notice challenged her with the need to get the transportation. The SW had a conversation with Resident #1 about discharge on Friday or Monday. She questioned about he

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being okay to discharge sooner as they had a 4-hour notice. Resident #1 reported she was fine with it, as it was better because then her sister did not have to come and get her.

A review of a voice recording from the transportation company, dated 10/25/23 at 7:28 AM, revealed that the SW called for a ride at that time without Resident #1 in the room with her. When the SW made the arrangements, she chose the 4-hour pick-up time and said "that works for me." They finalized the arrangements and once the company found a driver, they would notify them of the time of arrival.

On 11/14/23 at 12:12 PM a representative for the transportation company said that they usually only offer the 4-hour pickup option for an emergency; such as going to hospital or an important appointment, but they usually did a 48-hour pickup.

On 11/15/23 at 8:00 AM Staff N, Registered Nurse (RN), said that on the morning of the discharge the Administration rushed her to get a 7-day supply of medications prepared to send with Resident #1. Early that morning, Resident #1 went around to say good bye to other residents and staff. Later that morning when she found out that she only had a half hour to get everything together and packed she started to cry. Resident #1 expressed that she felt like the facility was kicking her out. Staff N said that she understood that they had a plan for discharge but it came very abruptly. Staff N reported she had concerned that Resident #1 went to a homeless shelter without nursing services especially when the provider just changed her hypertension medication that needed monitoring.

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On 11/9/23 at 12:15 PM, Staff H, Housekeeping Staff, said that on the morning of 10/25/23, she loaded up the remainder of Resident #1's belongings in her personal vehicle and drove them to the shelter. The transportation provider came with a very small car and they could not get all her items in that vehicle. As she helped Resident #1 pack her things, she appeared very angry, crying, and said that she felt the facility kicked her out. She kept asking to speak to someone above the Administrator about what was happening. She got to the shelter with Resident #1 items at about 1:30 PM that day.

On 11/9/23 at 8:15 AM Shelter Staff 1 (SS1) called back and said that the transportation company just dropped Resident #1 off at the shelter with no paperwork and no phone call. She said they did not typically accept residents from a hospital or nursing home that way. They need to know what level of care the resident required so they can determine if they are appropriate or if they can handle them. On 10/25/23 around 1:00 PM the transportation company dropped her off. Initially, the cab driver dropped her off at a safe house intended for domestic violence victims. The driver did not know what to do with her when they would not accept her there, so, they called the facility, who told them to take her to the homeless shelter. SS1 did the intake herself and then she had to leave early that day. Her daughter worked there in the afternoon and she called 911 due to Resident #1 shaking, falling, and unstable around 4:00 PM in the afternoon. At 6:15 AM on 10/26/23 the hospital returned her soiled back at the shelter. They got her a room to clean up and she talked to a friend on the phone. Around 11:00 AM on the 10/26/23, Resident #1's

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friend came and picked her up. She said she did not know what happened from there. They try not to get too involved in the resident's lives or situations once they leave the shelter. She said the facility made her very upset for just dropping off Resident #1 without first having a consultation on her level of need. She explained that "we have children here" and do not have nursing staff. She did call and talk to the SW who said that she did not make the arrangements and indicated that they would not take Resident #1 back because she made allegations against staff.

On 11/13/23 at 7:26 AM SS1 that she knew for a fact that no one talked to Shelter Staff 2 (SS2) before Resident #1 showed up at their door. She said that when they get residents from a facility or hospital, they put them on a list. When Resident #1 showed up she checked the list, which did not include her. SS2 called back to the facility the next day and talked to the SW but not before. SS1 was very sure of that because she is the manager, they all stay on top of who is calling and who is on the list. When Resident #1 showed up at their door, she told them that she did not know where they sent her. She said that they will never do business with that facility ever again or with "that SW lady."

On 11/13/23 at 2:32 PM SS2 said that the first day she talked to anyone at the facility was the day that Resident #1 showed up at their door. They write down their notes or document on the computer and they have no notes that someone contacted them regarding Resident #1 coming there. Resident #1 was at the door, concerned about the driver because he was on the phone with the facility. Originally, he went to the wrong place first and then did not know what to do with

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her things. Then the SW called back just after Resident #1 got there and SS2 told her that Resident #1 could barely walk, shook, and had shortness of breath. Resident #1 worried about holding up the driver. SS2 recalled her surprise when they started unloading all of Resident #1's things and said that they could only allow 2 bags. SS2 said that Resident #1 he had a TV and everything. SS2 talked to the SW on the phone telling her about Resident #1 not stable and she did not know if they could take care of her there. The SW told her that because of her behaviors they could not take her back. She told the SW that they did not know about her coming, the SW responded that she was sure someone took care of that. Staff 2 started the intake and later called non-emergent care to pick her up because she seemed so unstable. She did come with some medications, they are responsible for taking them on their own. Staff 2 said if Resident #1 stayed there before, it was a long time ago because she did not have a record of her being there.

The Encounter Note dated 10/24/23 at 12:00 AM signed by the Advanced Registered Nurse Practitioner (NP) on 10/26/23 at 8:08 PM reflected that Resident #1 saw the NP on 10/24/23. At that time, Resident #1 cried and stated that she had a lot of pain. They discussed getting her an appointment with the pain clinic. Resident #1 told her about her leaving the facility in 1-2 days, as the staff falsely accused her of being inappropriate with a staff member. She planned to leave and be at the homeless shelter for 6 months. The provider received a call from the facility on 10/25/23 indicating that day they planned to discharge Resident #1. The NP recommended to follow-up for medication refills in six months and she would provide a 7-day supply

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of medications.

The Blood Pressure Summary and Pulse (HR, an elevated pulse is over 100) Summary reviewed on 11/9/23 included the following results (low blood pressure considered to be below 90/60):
a. 10/17/23 at 4:14 PM 89/60, HR 112
b. 10/18/23 at 3:17 PM 96/62
c. 10/19/23 at 2:23 PM 84/55 HR 112

The Communication - With Physician Note dated 10/24/23 at 4:33 PM reflected the NP came to the facility and wrote the following new orders:
a. Discontinue clonidine (hypertension medicine)
b. Discontinue Coreg (hypertension medicine)
c. Start Metoprolol 25 MG (hypertension medicine that lowers pulse)
d. Complete lipids, complete blood count (CBC), comprehensive metabolic panel (CMP), thyroid stimulating hormone (TSH), and a hemoglobin A1C (lab test that measure your blood sugars over three months) labs, then repeat in 6 months.

A prescription dated 10/24/23 at 4:22 PM returned from the pharmacist noting that discontinuation of clonidine should not happen abruptly. Please consider tapering gradually and monitor for rebound hypertension.

The Communication - With Physician Note dated 10/25/23 at 2:09 AM indicated that the Pharmacy faxed that discontinuation of clonidine should not happen abruptly due to rebound hypertension (withdrawal syndrome that occurs when discontinuing antihypertensive drugs abruptly, leading to a rapid increase in blood pressure without symptoms). The facility notified the NP via fax.

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The Nurses Note dated 10/25/23 at 10:58 indicated the facility received a telephone order from the NP to discharge with current medication and treatment orders to the homeless shelter.

The Orders - Administration Note dated 10/25/23 at 10:02 AM indicated that Resident #1 did not receive her dressing change or lab work because she discharged home.

The Discharge Summary dated 10/25/23 at 12:00 PM identified that Resident #1 discharged to the homeless shelter on 10/25/23. Resident #1 refused to provide a primary care physician or a preferred pharmacy upon discharge. She gave verbal agreement of an accurate account of her items at discharge. The facility notified Resident #1's Case Worker and lawyer of her discharge.

The Order Note dated 10/25/23 at 1:59 PM, the NP gave a new order to decrease clonidine to 0.1 mg daily instead of discontinuing.

On 11/14/23 at 10:04 AM the Pharmacist reported a clinical concern of an increased risk of rebound hypertension with an abrupt stop of clonidine. The Pharmacist recommended a titrated decrease with monitoring. She said that with an abrupt stop to the medication she would recommend twice a day blood pressure monitoring.

The Clinical Physician's Orders listed the clonidine 0.2 milligrams twice daily as discontinued on 10/24/23.

On 11/14/23 at 10:42 AM Staff N, Registered Nurse (RN), said that if the NP discontinued the medication on 10/24/23, she would not have included it with the 7-day supply.

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On 11/13 at 1:39 PM The Director of Nursing (DON) stated that she could not find a copy of the list of medications that went with the resident upon discharge.

On 11/14/23 at 9:00 AM the Regional Director of Nursing (RDON) said that she assisted with Resident #1's discharge. She maintained that she gave her a list of her medication, diagnoses, Care Plan, and a summary of her stay. She said that while she went through the discharge with Resident #1, the Administrator poked her head in the room. Resident #1 called her a "bitch" but did not say why the Administrator upset her. She said that Resident #1 did not share any concerns with her and she had offered her other avenues to file grievance but she was not interested. She maintained that they planned the discharge since 10/9/23. Resident #1 knew about it and agreed to the transfer. She said that as they packed things up, Resident #1 said that she thought that she could only have 3 bags of items at the shelter, but the SW disagreed with her, and said that they would take all her things.

11/15/23 at 11:08 AM The Director of Nursing (DON) said that she did not know that they discontinued Resident #1's abruptly and that the pharmacy recommended not to stop the medicine abruptly. She agreed that Resident #1's blood pressure (BP) needed monitoring after the medication change. She did not assist with the discharge due to her not being available when all the discharge activity and decisions happened. She said that she did not know if anyone consulted nursing to see about any reason why they should delay Resident #1's discharge.

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According to the Discharge Summary dated 10/25/23 the most recent vital signs included in the summary included a blood pressure taken on 10/19/23 at 84/55 and a pulse of 112 beats per minute.

On 11/16/23 at 10:58 AM Staff D said that they consulted her with the discharge planning for Resident #1 and that she knew about going to the homeless shelter. She did not know about the change in medication or the recommendation from pharmacy to follow up with blood pressure (BP) monitoring. She said that ideally, she would have liked to see a set of vitals on the day of discharge. If the Resident #1 status had concerns, they would arrange for a follow-up with the receiving entity. She maintained that the facility did a well-planned and safe discharge. With BP concerns, perhaps a BP cuff would have been appropriate for the resident to use. She said that the resident was aware enough to manage her health needs but when there were medication changes close to discharge it can be concerning. When asked why the facility rushed to discharge Resident #1 or why they did not wait to monitor her for a couple of days, Staff D expressed that they did not rush the discharge. She added that the transportation arrangements made it seem that way, but they could not control that.

The Transfer or Discharge Documentation policy revised December 2016 directed that if a resident transferred or discharged, the facility must document the details of the transfer or discharge in the medical record, and communicate appropriate information to the receiving health care facility or provider.
The facility may initiate transfer or discharge for the following: a. Necessary for the resident's

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F 622	Continued From page 56 welfare and the facility cannot meet their needs. b. The resident's health improved significantly so that the resident no longer needs the care or services. c. The resident's clinical or behavioral status endangered the safety of individuals in the facility. d. The resident's clinical or behavioral status endangers the health of individuals in the facility. e. The resident failed to pay after reasonable and appropriate notice. f. Facility ceases to operate.	F 622		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform	F 660		

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required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based

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on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, interviews with staff and residents and policy review the facility failed to meet a resident's needs related to discharge planning for 1 of 3 residents reviewed. Resident #1 was discharged abruptly after allegations of abuse and was sent to a homeless shelter that was unaware that she was coming and could not meet her medical needs. The facility reported a census of 30 residents.

Findings include:

Resident #1's Minimum Data Set (MDS) assessment dated 9/24/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment reflected that Resident #1 did not have behaviors. Resident #1 required limited assistance from one person for transfers, dressing, toilet use, and personal hygiene. The MDS listed Resident #1 as frequently incontinent of urine and always continent of bowel. The MDS included diagnoses of disorder of the kidney, heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and malignant neoplasm of upper lobe (lung cancer). The assessment indicated that Resident #1 almost always had

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pain.

The Care Plan included the following Focuses dated 10/3/23:
a. Resident #1 planned to rehab to home. The Goal listed that Resident #1 would transition back to the community.
b. Activities of daily living (ADLs). The Interventions directed that Resident #1 could independently provide her own hygiene, toilet use, and transfers.
c. Resident #1 is independent in the facility. The Interventions reflected that Resident #1 used a front wheel walker.

A Social Service note dated 10/10/23 indicated that the Social Worker met with Resident #1's Case Worker and Resident #1. The discussion included that Resident #1 had no family support. Resident #1 claimed her youngest son as her only advocate. The conversation listed two different options as discharge options, but Resident #1 preferred the homeless shelter as she had a better chance with reuniting with her son. The note lacked a planned date for discharge.

On 11/6/23 at 2:13 PM, Resident #1 said that when she reported her abuse to a couple of staff members, somehow, they twisted the story around. Due to this she did not trust anyone at the facility any more. She said that the Administrator came into her room one day, yelling, and told her that she had to leave because the staff reported that she provided sexual favors for cigarettes. Resident #1 said that staff took her outside to have cigarettes, and she shared with a couple of them. Staff I sexually attacked her. She could not remember the date

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when Staff I took her to his car and made her perform oral sex on him. Resident #1 said when planning her discharge, the Social Worker (SW) told her that she planned to help her find housing so her son could come and live with her. The SW offerred a homeless shelter as option but her son could not go there due to his age. She said she felt like the facility kicked her out because of the lies told about her.

On 11/8/23 at 11:12 AM the Social Worker (SW) reported the transfer of Resident #1 to the homeless shelter as appropriate as she came from there per her lifestyle choice. Resident #1 always had a goal to discharge and reunite with her son. When asked if she told the staff at the shelter the level of need before sending Resident #1 to the shelter, she replied "yes and no." The SW continued by expressing Resident #1's "behaviors" related to impulsivity and lack of follow through. When inquired about Resident #1's level of medical needs, she responded that therapy told her that Resident #1 could use a walker. The Regional Director of Nursing arranged to get her a walker to take with her but she wanted to get out. She said that after Resident #1's admission to the shelter, she called 911 that night, but she did not know what happened after that. She denied knowing anything about Staff I or cigarettes. She maintained that she had Resident #1's permission to make the arrangements to go to the shelter.

On 11/9/23 at 10:45 AM during a telephone call, the SW said that the Administrator reached out to the homeless shelter to ask about admitting her. Afterwards, she made the transportation arrangements. She said that she got a call from a

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very upset shelter representative the next day about Resident #1 and said that she "faked a heart attack." They sent her to the hospital, and they could see what she was like. The SW told her that they could not take her back because of her behaviors and manipulation. She met all her goals and she wanted to go to there. When questioned about if she sent Resident #1's medical information with her, she replied no, as a homeless person off the street did not come into a shelter with their medical diagnosis information. As that is what they do.

On 11/13/23 at 3:00 PM the SW said that they put a discharge checklist on the wall in her office so they can go down the list and make sure they are hitting on the planning points. She said the 24-hour notice challenged her with the need to get the transportation. The SW had a conversation with Resident #1 about discharge on Friday or Monday. She questioned about her being okay to discharge sooner as they had a 4-hour notice. Resident #1 reported she was fine with it, as it was better because then her sister did not have to come and get her.

A review of a voice recording from the transportation company, dated 10/25/23 at 7:28 AM, revealed that the SW called for a ride at that time without Resident #1 in the room with her. When the SW made the arrangements, she chose the 4-hour pick-up time and said "that works for me." They finalized the arrangements and once the company found a driver, they would notify them of the time of arrival.

On 11/14/23 at 12:12 PM a representative for the transportation company said that they usually only offer the 4-hour pickup option for an emergency;

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such as going to hospital or an important appointment, but they usually did a 48-hour pickup.

On 11/15/23 at 8:00 AM Staff N, Registered Nurse (RN), said early that morning, Resident #1 went around to say good bye to other residents and staff. Later that morning when she found out that she only had a half hour to get everything together and packed she started to cry. Resident #1 expressed that she felt like the facility kicked her out. Staff N said that she understood that they had a plan for discharge but it came very abruptly. Staff N reported that she had concerns that Resident #1 went to a homeless shelter without nursing services especially when she needed monitoring as the provider just changed her hypertension medication.

On 11/9/23 at 12:15 PM, Staff H, Housekeeping Staff, said that on the morning of 10/25/23, she loaded up the remainder of Resident #1's belongings in her personal vehicle and drove them to the shelter. The transportation provider came with a very small car and they could not get all her items in that vehicle. As she helped Resident #1 pack her things, she appeared very angry, crying, and said that she felt the facility kicked her out. She kept asking to speak to someone above the Administrator about what was happening. She got to the shelter with Resident #1 items at about 1:30 PM that day.

On 11/9/23 at 8:15 AM Shelter Staff 1 (SS1) called back and said that the transportation company just dropped Resident #1 off at the shelter with no paperwork and no phone call. She said they did not typically accept residents from a hospital or nursing home that way. They need to

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know what level of care the resident required so they can determine if they are appropriate or if they can handle them. On 10/25/23 around 1:00 PM the transportation company dropped her off. Initially, the cab driver dropped her off at a safe house intended for domestic violence victims. The driver did not know what to do with her when they would not accept her there, so, they called the facility, who told them to take her to the homeless shelter. SS1 did the intake herself and then she had to leave early that day. Her daughter worked there in the afternoon and she called 911 due to Resident #1 shaking, falling, and unstable around 4:00 PM in the afternoon. At 6:15 AM on 10/26/23 the hospital returned her soiled back at the shelter. They got her a room to clean up and she talked to a friend on the phone. Around 11:00 AM on the 10/26/23, Resident #1's friend came and picked her up. She said she did not know what happened from there. They try not to get too involved in the resident's lives or situations once they leave the shelter. She said the facility made her very upset for just dropping off Resident #1 without first having a consultation on her level of need. She explained that "we have children here" and do not have nursing staff. She did call and talk to the SW who said that she did not make the arrangements and indicated that they would not take Resident #1 back because she made allegations against staff.

On 11/13/23 at 7:26 AM SS1 that she knew for a fact that no one talked to Shelter Staff 2 (SS2) before Resident #1 showed up at their door. She said that when they get residents from a facility or hospital, they put them on a list. When Resident #1 showed up she checked the list, which did not include her. SS2 called back to the facility the next day and talked to the SW but not before.

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SS1 was very sure of that because she is the manager, they all stay on top of who is calling and who is on the list. When Resident #1 showed up at their door, she told them that she did not know where they sent her. She said that they will never do business with that facility ever again or with "that SW lady."

On 11/13/23 at 2:32 PM SS2 said that the first day she talked to anyone at the facility was the day that Resident #1 showed up at their door. They write down their notes or document on the computer and they have no notes that someone contacted them regarding Resident #1 coming there. Resident #1 was at the door, concerned about the driver because he was on the phone with the facility. Originally, he went to the wrong place first and then did not know what to do with her things. Then the SW called back just after Resident #1 got there and SS2 told her that Resident #1 could barely walk, shook, and had shortness of breath. Resident #1 worried about holding up the driver. SS2 recalled her surprise when they started unloading all of Resident #1's things and said that they could only allow 2 bags. SS2 said that Resident #1 he had a TV and everything. SS2 talked to the SW on the phone telling her about Resident #1 not stable and she did not know if they could take care of her there. The SW told her that because of her behaviors they could not take her back. She told the SW that they did not know about her coming, the SW responded that she was sure someone took care of that. Staff 2 started the intake and later called non-emergent care to pick her up because she seemed so unstable. She did come with some medications, they are responsible for taking them on their own. Staff 2 said if Resident #1 stayed there before, it was a long time ago because she

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did not have a record of her being there.

On 11/14/23 at 9:00 AM the Regional Director of Nursing (RDON) said that she assisted with Resident #1's discharge. She maintained that she gave her a list of her medication, diagnoses, Care Plan, and a summary of her stay. She said that while she went through the discharge with Resident #1, the Administrator poked her head in the room. Resident #1 called her a "bitch" but did not say why the Administrator upset her. She said that Resident #1 did not share any concerns with her and she had offered her other avenues to file grievance but she was not interested. She maintained that they planned the discharge since 10/9/23. Resident #1 knew about it and agreed to the transfer. She said that as they packed things up, Resident #1 said that she thought that she could only have 3 bags of items at the shelter, but the SW disagreed with her, and said that they would take all her things.

On 11/15/23 at 11:08 AM The Director of Nursing (DON) said that she did not know that they discontinued Resident #1's abruptly and that the pharmacy recommended not to stop the medicine abruptly. She agreed that Resident #1's blood pressure (BP) needed monitoring after the medication change. She did not assist with the discharge due to her not being available when all the discharge activity and decisions happened. She said that she did not know if anyone consulted nursing to see about any reason why they should delay Resident #1's discharge.

The Transfer or Discharge Documentation policy revised December 2016 directed that if a resident transferred or discharged, the facility must document the details of the transfer or discharge

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F 660	Continued From page 66 in the medical record, and communicate appropriate information to the receiving health care facility or provider.	F 660		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure they provided adequate administration services. Upon allegations of abuse, the administrator failed to conduct a thorough investigation, failed to report the allegations to the proper authorities, and abruptly discharged the resident who made the allegation (Resident #1). The facility reported a census of 30 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated 9/24/23 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment reflected that Resident #1 did not have behaviors. Resident #1 required limited assistance from one person for transfers, dressing, toilet use, and personal hygiene. The MDS listed Resident #1 as frequently incontinent of urine and always continent of bowel. The MDS included diagnoses of disorder of the kidney, heart failure, hypertension (high blood pressure), diabetes	F 835		

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mellitus, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and malignant neoplasm of upper lobe (lung cancer). The assessment indicated that Resident #1 almost always had pain.

On 11/8/23 at 10:48 AM, Staff A, Dietary Aide (DA), said that on the evening of 10/23/23 while she waited outside of the facility for a ride after her shift and sat with Resident #1 on the patio. Resident #1 told her that Staff I, Certified Nurse Aide (CNA), bought her cigarettes, then he took her phone and transferred money into his own Cash App. After this, Resident #1 told Staff A that he took her to his car one night and forced her to perform oral sex on him. Resident #1 said that they were drinking alcohol and she did not want anyone to know about it. Staff F, Nurse Aide (NA), then stopped over and entered the conversation when Resident #1 told them that she had a video from Staff I, but she needed to charge her phone, so she could not show them. She said that Resident #1 trembled when she told them the story and expressed fear of what he might do if he knew she told anyone.

On 11/8/23 at 10:32 AM, Staff F said that on the evening of 10/23, Resident #1 sat outside with Staff A and when she approached, Staff A looked at her and asked "can I tell her?" Resident #1 shook her head "yes" and Staff A proceeded to tell her that Staff I sent her a video of himself masturbating. They agreed that they needed to report this to the Administrator. The next morning at around 10:00 AM they both went in to talk to the Administrator.

On 11/8/23 at 2:18 PM, the Administrator said that on 10/24/23, a couple of staff members told

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her about a situation with Staff I buying cigarettes for Resident #1, and that he used a Cash App on his phone. The Administrator said that she had Staff I come into her office that morning. He showed her the Cash App receipt on his phone for $10.00, and she suspended him from the building. When asked about the allegations of sex, the Administrator said that she confronted Resident #1 about providing sexual favors for cigarettes, but she denied it. She said that Staff I denied any sexual activity with Resident #1. He acknowledged that he would take her out to smoke but denied anything sexual. The Administrator said that Resident #1 wrote a letter stating that it was false and denied everything.

A hand-written note dated 10/24/23 at 8:52 AM, signed by Resident #1, indicated that the Administrator confronted Resident #1 and accused her of providing sexual favors for cigarettes. Resident #1 reported being very upset by the allegations, and that she would never do anything so vile. She denied the allegations and the hand-written note lacked any reference to forced sexual acts.

The Care Plan Focus dated 10/3/23 reflected that Resident #1 planned to rehab to home. The Goal listed that Resident #1 would transition back to the community.

According to an untitled and undated facility investigation, two staff members reported to the Administrator that Resident #1 voiced concerns about Staff I. She indicated that the concerns were related to the purchase of cigarettes and when Resident #1 went to Staff I's car to get cigarettes, he made a gesture of oral sex while outside his car. When asked about the incident,

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Resident #1 denied that it occurred. The investigation indicated that Resident #1 had a history of making false stories and exaggerating events to gain attention. The Administrator separated Staff I from the facility and he admitted to purchasing cigarettes for Resident #1. The investigation statement included comments that the staff member who reported the abuse, had a history of making allegations against Staff I, and that many staff and residents at the facility had a history of making false allegations against African Americans. The statement indicated the facility contacted law enforcement on 10/24/23.

The investigation included an undated list of resident interviews, the investigation lacked staff interviews, and a resident assessment.

On 11/14/23 at 8:47 AM a representative from the sheriff's office went through the files to see if they got any calls from the facility on 10/24 or 10/25 about possible abuse with Resident #1 as the victim. The staff reported that they did not have any calls from the facility regarding abuse allegations.

On 11/9/23 at 8:50 AM, Staff I said that on 10/24/23, his schedule had him working a 6a-6p shift. At around 9:00 AM, the Administrator called him into her office. She asked him if he purchased cigarettes for a resident, he told her that he did and showed her the Cash App. He said "the lady sent me money and I bought her cigarettes." The Administrator asked him if he ever took Resident #1 in his car to go purchase cigarettes and he told her that he did not. He said he chose to leave the facility on 10/24/23 because he would not feel comfortable working there anymore. He said that he went to a sister

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facility and finished up a shift that same day. He denied having any kind of relationship with Resident #1 and said that he would sit with her a little bit on the patio. He denied sending her any messages and said that he did not feel he did anything wrong with accepting her money for the purchase of cigarettes. Staff I went on to say that he worked in different states and did not have a problem with buying things for residents. Staff I said that he did not spend much time with Resident #1. When asked if he thought that she had the wrong impression about their relationship, Staff I asked what the questions were about and did not understand the reason for the interview. He maintained that the Administrator did not bring up or ask about any sexual interactions between him and Resident #1. Staff I then chuckled and said that he worked as an intelligence officer and learned to record things. He thought that he may have a recording of the interaction between himself and the Administrator. He said "I am keeping my magnetism, I can overcome obstacles ... I am a stellar worker." He said that the company begged him to work other shifts since 10/24/23. He mentioned three other facilities that he completed shifts after the 24th. He did not understand that if they thought he did something wrong, why they allowed him to continue to work for the company? He reported feeling upset and described the allegations as preposterous.

On 11/14/23 at 9:00 AM the Regional Director of Nursing said that their leadership team had a "rapid response" phone call regarding the concern with Resident #1 on 10/24/23. She said that most of the conversation was related to the concern about money exchange from resident to staff. The conversation included very little

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discussion regarding sexual innuendos. She said that the Administrator conveyed to them that Staff I only made a motion that simulated masturbation. The meeting did not include anything about allegations of forced sexual activity.

On 11/14/23 at 2:50 PM the Regional Manager said the rapid response team did not get all the information, or accurate information from the Administrator to determine the next steps. She said that had they known all the details, they would have made different decisions.

According to an annual facility survey report dated 10/19/22, Staff I recorded a resident without her consent or knowledge. His personal file lacked a corrective action form or any indication that the facility addressed that incident with him.

Staff I's timesheet showed that he continued to work with vulnerable elderly population in their facilities on 10/24/23 from 2:04 PM - 7:02 PM, 10/28/23 from 10:19 PM - 6:14 AM, and on 10/30/23 at 10:01 PM - 6:00 AM.

The Facility's Job Description for the position of Administration revised April 2018, described the Essential Functions for General Management as to operate the facility in accordance with the established company policies and procedures in compliance with federal, state and local regulations. They would assume responsibility for notifying appropriate state and local agencies of transfer either temporary or permanent. They assure that staff implements programs and services to assess and meet the health and psychosocial needs of the residents.

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